

Fifth Amendment to the IME Professional Services, Revenue Collections including Estate Recovery Services Contract

This Fifth Amendment to Contract Number MED-10-001-F for Iowa Medicaid Services, as amended (the "Contract"), between the State of Iowa, Department of Human Services (the "Agency", "Department" or "DHS") and Health Management Systems, Inc. (the "Contractor") is made pursuant to Section 22.5 of the Contract. This Amendment is effective as of March 1, 2016. This Amendment modifies, to the extent specified below, the terms and conditions of the Contract.

Section 1: Background. The parties are amending the Contract to reflect the delay in Medicaid modernization, with a new expected "go live" date of April 1, 2016 for implementation of modernization efforts. This amendment accommodates a reduction in volume of Contractor services beginning the month of "go live," and therefore expected in April 2016, and running through the end of the Contract. These changes in fees and staffing are based on an expectation that approximately 90% or more of the current Fee for Service members will transition to the MCO vendors within 30 days or less of the go-live date. In the event this transition is not executed within this 30 day time frame the parties agree to negotiate in good faith and enter into an additional amendment to the Agreement adjusting timing, fees and staffing accordingly.

Section 2: Amendment to Contract Language

The Contract is amended as follows:

Revision 1. The document titled Exhibit A, which was incorporated into the Contract through Amendment 4, is hereby deleted and replaced with the attached Exhibit A. The clauses set forth in Exhibit A amend and/or replace all of Contractor's Revenue Collections scope of work as set forth in Section 6.4 of the RFP. Contractor's Estate Recovery scope of work, as outlined in Section 6.8 of the RFP, remains unchanged.

Revision 2: Section 7.1, Performance Based Contract, paragraphs added through Amendment 4 beginning, "Notwithstanding the above," and ending with "5% contingency fee on SFY17 recoveries from Lien Recovery (RFP Section 6.6.3)," are hereby deleted in their entirety.

Revision 3: Section 7.1, Performance Based Contract, is hereby amended by adding the following language at the end of the Section:

Notwithstanding the above, the above payment obligations shall terminate as of April 1, 2016. Beginning April 1, 2016, Contractor may invoice the Department \$229,000 per month for services performed April through September 2016. Beginning in October 2016, Contractor may invoice the Department \$189,500 per month through the remainder of the contract.

In addition to the fixed fee pricing above, the Contractor may invoice the following amounts:

- 8.5% contingency fee on recoveries from Estate Recovery.
- 5% contingency fee on October 2016 through June 2017 recoveries from Lien Recovery (RFP Section 6.6.3).

Section 3: Ratification & Authorization

Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof. Each party to this Amendment represents and warrants to the other that it has the right, power, and authority to enter into and perform its obligations under this Amendment, and it has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment, and this Amendment constitutes a legal, valid and binding obligation upon itself in accordance with its terms.

Section 4: Execution

IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

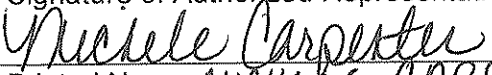
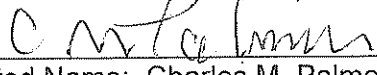
Health Management Systems, Inc.	Agency, Iowa Department of Human Services
Signature of Authorized Representative: 	Signature of Authorized Representative: 
Printed Name: MICHELE CARPENTER	Printed Name: Charles M. Palmer
Title: SENIOR VICE PRESIDENT	Title: Director
Date: MARCH 28, 2016	Date: 4-1-16

Exhibit A to Amendment 5
{Replacement of RFP Section 6.6}

6.6 Revenue Collections

The Revenue Collections contractor is generally responsible for all third-party liability (TPL) activities for the Iowa Medicaid Program. The Revenue Collections component encompasses an array of collection functions for the Medicaid program, including identification and recovery of funds owed to the Department as a result of third-party insurance payments, liens, tax offsets and provider overpayments. The third-party insurance function is the major activity of this component, which includes identifying third-party insurance resources, updating the TPL files, identifying funds to be recovered, requesting funds from the liable party, tracking and follow-up on the requests, and tracking payments received. The Revenue Collections section includes the following topics:

- 6.6.1 General Requirements
- 6.6.2 TPL Recovery
- 6.6.3 Lien Recovery
- 6.6.4 Provider Overpayment
- 6.6.5 Provider Withholds
- 6.6.6 MEPD and IHAWP Premium Payments
- 6.6.7 Credit Balance Recovery
- 6.6.8 Iowa-Based Yield Management Activities

6.6.1 General Requirements

Following are the general requirements for the Revenue Collections component.

6.6.1.1 State Responsibilities

- a. Monitor Revenue Collections contractor performance.

6.6.1.2 Contractor Responsibilities

- a. Pursue collections and track payments received.
- b. Work as part of a larger integrated unit consisting of staff from other contractors obtained through this procurement, plus requisite state employees.
- c. Ensure that the money amounts of each provider withhold do not exceed the state or federal regulations governing monetary garnishments. For example, current statutes do not allow for more than 50 percent of an individual's income to be garnished at each payment interval for child support payments.
- d. Within one business day of their preparation for deposit, deposit checks or money orders received at the Iowa Medicaid Enterprise (IME) facility by all contractors to the state-owned Title XIX recovery bank account.
- e. Provide deposit receipt and a check log to the Department within 24 hours of depositing the refund checks. The log should include the daily beginning number and amount of checks located in the state-owned safe, the number and amount of the daily deposit, and

the ending number and amount of checks located in the state- owned safe.

- f. Research and obtain correct addresses for returned checks of providers and mail returned checks to new addresses for providers once the corrected information is updated in Medicaid Management Information System (MMIS) by the IME Provider Services unit.
- g. Void returned checks when the provider cannot be located or when the provider notifies the IME that the claims are to be voided.
- h. If the provider does not contact the IME, hold the undeliverable check for 30 days from the issuance date and then void the check.
- i. Deposit undeliverable checks into the state-owned Title XIX recovery bank account on day 31 or the next banking day.
- j. Submit credits or adjustments associated with the claims for the non-deliverable check to the Core MMIS contractor within 10 business days of depositing the undeliverable check.

6.6.2 TPL Recovery

TPL recovery consists of identifying and verifying third-party resources for Medicaid members, updating the TPL files, and recovering funds from third-party insurers for pay-and-chase claims. Following are the primary inputs to the TPL subsystem:

- a. Insurance Questionnaire (IQ), Form , 470-2826 or 470-2826(S) received by the IME
- b. Health insurance premium payment (HIPP) file showing individuals with TPL for whom the Department has paid the premium
- c. IV-D (child support) report by the IME for non-custodial court-ordered medical support
- d. Any correspondence or phone calls received by the IME from members, carriers, providers, employers, field staff and the Centers for Medicare and Medicaid Services (CMS)
- e. TPL-related data from processed claims including but not limited to claims that indicate any evidence of TPL on the claim. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- f. Other files used in the TPL process for reference data, including the recipient eligibility file, claims files, procedure, drug, diagnosis, diagnosis related group (DRG), ambulatory payment classification (APC) and exception control files. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- g. Medicare Part A and Part B disallowance five (5) times per year. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- h. HMS Data Match completed within the first thirty (30) days of medical eligibility and ongoing. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- i. Error Reports generated from the MMIS
 - 1. Data match deliverable from the HMS file and MCO files that generate Error Reports for any reason
 - 2. Error Reports are to be re-verified and entered into the MMIS TPL Subsystem based upon section 6.6.2.2 guidelines

6.6.2.1 State Responsibilities

- a. Establish and direct TPL policies.
- b. Receive and review TPL reports.
- c. Provide the SIQ forms on members with potential TPL to the Revenue Collections contractor for verification of the third-party coverage and updating the MMIS.
- d. Manage the TPL action plan that is approved by CMS.

6.6.2.2 Contractor Responsibilities

The Core MMIS contractor and the Revenue Collections contractor perform TPL processing functions. The Core MMIS contractor maintains the TPL data and performs cost avoidance activities through the claims processing function. The Revenue Collections contractor performs the manual processes associated with the TPL function, including verification of insurance coverage for the Fee-For-Service population and MCO population in the first thirty (30) days of coverage, and ongoing for any TPL correspondence received by the IME as per 6.6.2.

- a. Contractor shall meet the following objectives:
 - 1. Identify and verify third-party resources for Medicaid members
 - 2. Pursue recovery of third-party insurance payments for claims designated by the Department as pay-and-chase
 - 3. Meet federal and state reporting requirements for TPL activities
- b. Maintain the following interfaces:
 - 1. Members and Medicaid providers to obtain information on third-party insurance coverage
 - 2. Insurance companies to verify coverage and submit pay-and-chase claims
- c. Verify insurance coverage for Medicaid members based upon claims information, IQ forms, or any other forms of TPL notification submitted to the IME
- d. Perform all recovery activities for pay-and-chase claims, which includes submission of claims to third-party insurers, recovery tracking, receipt of recovery payments, and production of reports on recovery activities. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- e. Update and maintain the IME third-party carrier code list. This includes carrier ID and name, address, city, state and zip code, phone number and name of contact person. Communicate with and respond to MCO data requests regarding the carrier code list.
- f. Maintain third-party resources by member ID on the TPL subsystem of the MMIS that must, at a minimum, include:
 - 1. First and last names of policyholder
 - 2. Social security number (SSN) of policyholder
 - 3. Full insurance company name
 - 4. Group number, if available
 - 5. Name and address of policyholder's employer, if known
 - 6. Insurance carrier ID

7. Type of policy and coverage, including identification of covered types of services under the policy
8. Effective date of coverage, if new
9. Termination date of coverage, if ended
- g. Maintain the integrity of the MMIS TPL subsystem by working DDM ad hoc TPL gap reports, including but not limited to:
 1. When a member is approved for Medicaid and there is an active segment that hasn't been verified in over a year (12 months);
 2. Active only Rx;
 3. When medical insurance is coded in the system, but lacks the prescription coverage. If the prescription covered is not loaded, then the claim will not be cost avoided, or pay and chased; and
 4. For Aid Types 920, 308, 380 and coded as having absent parent insurance:
 - i. If the member is coded as an adult and the absent parent policy is still active, term the AP policy and convert it to a TPL in order to cost avoid instead of pay and chase
 - ii. If the member is coded as a child and turns 19, if the policy is still active, switch the AP policy to a regular policy in order to cost avoid instead of pay and chase
- h. Identify paid claims for TPL tracking and potential recovery, including all federally mandated pay-and-chase services. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- i. Track and recover paid claims denied by insurance carriers. Identify and record reasons for denial of post-payment billed claims by TPL carrier. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- j. Reserved.
- k. When retroactive TPL resources are found, identify paid claims for up to three years prior and bill insurance carrier for these claims. Identify type and amount of recovery, utilizing the paid claims file. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- l. Reserved.
- m. Meet all minimum TPL processing requirements defined in Chapter 3, Section 3900 of the State Medicaid Manual.
- n. Track and adjudicate all post-payment requests for reimbursement to a final payment or denial and identify denial by type and reason. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- o. Perform data matches with other governmental and private insurers as required to identify TPL resources.
- p. Provide subject matter expertise and Iowa claims data for regular, ongoing TPL-related national settlements and mass torts. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- q. Produce the following reports. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
 1. Reports to meet federal and state requirements:
 - i. Amounts billed and collected, current and year-to-date (monthly)

- ii. Recoveries and unrecoverable amounts by carrier, type of coverage, and reason (quarterly)
 - iii. CMS-approved TPL action plan (as needed)
- 2. TPL activity reports (quarterly)
- 3. Internal reports used to investigate possible third-party liability when a paid claim contains a TPL amount and no resource information is on file
- 4. Monthly quality assurance sample to the Department verifying the accuracy of TPL updates applied during the previous month
- 5. Monthly pay-and-chase carrier bills
- r. Assist the Department in defining its TPL responsibilities and report any changes in content of the TPL Action plan to the Department.
- s. Initiate follow-up activities on denied post-payment billings as agreed with the Department within five business days of receipt of the denial notice. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- t. Log and prepare all TPL recoveries to be deposited in the state-owned Title XIX recovery bank account according to Request for Proposal (RFP) Section 6.1.8 Banking Policies. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- u. Deposit all payments received by all IME units except Estate Recovery Services to the Title XIX recovery bank account according to Request for Proposal (RFP) Section 6.1.8 Banking Policies.
- v. Handle all error reports generated from the MMIS Data Match and MCO TPL deliverables, including verifying coverage and updating it in the MMIS TPL Subsystem. This work includes performing a quality assurance validation of the load based on sampling to identify any possible trends or issues needing to be addressed with the MCOs or IME leadership for the FFS population.
- w. Process all local leads received at the IME for FFS and MCOs.

6.6.2.3 Performance Standards

- a. Deposit all TPL recovery amounts within two (2) business days and post/apply all denial information within sixty (60) business days of receipt.
- b. Initiate follow-up activities on unpaid post payment carrier billings within ninety (90) business days.
- c. Complete the verification or validation of any TPL leads received at the IME including any leads related to the MCO population; update the MMIS TPL Subsystem with the data within sixty (60) business days of receiving the lead.
- d. Ensure accuracy of TPL data in MMIS TPL Subsystem based on the monthly quality assurance audit of the sample data. The quality assurance audit should consist of a one (1) percent sample of all new policies added or termed policies deleted for the prior month.
- e. Report to the Department all third-party health insurance coverage information for Medicaid members within ten (10) business days of the end of each month.
- f. Respond to MCO carrier code data requests within two (2) business days.

6.6.3 Lien Recovery

The lien recovery process consists of identifying trauma, accident, and medical malpractice cases for which a third party is potentially liable, pursuing recovery from the third party, and receiving and tracking funds recovered for trauma, accident, and medical malpractice cases. The Revenue Collections contractor uses TPL-related data from the claims processing function, including but not limited to indicators of accident-related treatments and trauma-related diagnoses.

6.6.3.1 State Responsibilities

- a. Identify trauma, accident, and medical malpractice related diagnoses and procedures.
- b. Arrange for the Core MMIS contractor to provide the Revenue Collections contractor with reports identifying accident related diagnoses and procedures, by member.
- c. Identify minimum dollar expenditures for pursuing recovery.
- d. Monitor the contractor's performance of the lien recovery activities.
- e. Pursue medical malpractice claims identified through lien recovery or by other means.

6.6.3.2 Contractor Responsibilities

Effective April 1, 2016, Contractor's obligations under this section are only applicable to the Fee-For-Service population.

- a. Meet the following objectives:
 - 1. Identify trauma, accident, and medical malpractice cases where funds expended by Medicaid can be recovered from liable third parties.
 - 2. Recover funds from liable third parties for trauma, accident, and medical malpractice cases.
- b. Maintain the following interfaces:
 - 1. Liable third parties
 - 2. Attorneys for members
- c. Review claims with trauma indicators to identify potential cases for subrogation; prepare records of the medical services provided to the member based on the medical assistance claims.
- d. Identify potential cases for subrogation and prepare reports of the amount of medical services provided to the member based on the medical assistance claims data.
- e. Provide case data to the state attorney general's office for subrogation cases that are appealed.
- f. Track all subrogation cases from initial intake to final disposition. Provide a monthly report of these cases to the Department within 10 business days following the end of each month.
- g. Maintain a process or utilize a tool to select individual claims online to build recovery cases (such as tort cases related to auto accidents).
- h. Provide to the Department the following types of reports to meet federal and state requirements:
 - 1. Listings of potential recovery claims based on user input section parameters (subrogation)
 - 2. Amounts billed and collected, current, and year-to-date (monthly)
 - 3. Potential trauma, accident, or medical malpractice claims (monthly)

- i. Log and prepare all recoveries to be deposited in the state-owned Title XIX recovery bank account according to RFP Section 6.1.8 Banking Policies.

6.6.3.3 Performance Standards

- a. Provide monthly reports of lien recovery activity by the tenth business day of the month with state fiscal year-to-date data and updated for the previous month's activity.
- b. Prepare and process credits or adjustments against recoveries received within 20 business days.

6.6.4 Provider Overpayment

The provider overpayment function consists of receiving refunds from providers and processing adjustments associated with the refunds for overpayments from providers payments received from claims. The data sources for the provider overpayment function are:

- a. Provider refunds
- b. Returned warrants
- c. Claims history

6.6.4.1 State Responsibilities

- a. Determine policies regarding processing of provider overpayments.
- b. Review and approve contractor's procedures for processing provider overpayments.
- c. Provide the bank account for deposit of refund checks from providers.
- d. Monitor the contractor's performance of the provider overpayment function.

6.6.4.2 Contractor Responsibilities

- a. Meet the following objectives. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
 - 1. Identify providers who have been overpaid, through interfaces with the Core MMIS
 - 2. Receive refund checks and returned warrants from providers.
 - 3. Process claim adjustments for provider refunds to update claims history on the MMIS claims system
 - 4. Ensure that refund checks and returned warrants are controlled and processed according to procedures approved by the Department.
- b. Maintain the following interfaces. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
 - 1. Providers for receipt of refunds and requesting additional information if necessary to process the refunds
- c. Prepare and process credits or adjustments against refund checks, including credits or adjustments resulting from provider audits with recoveries performed by the Department of Inspections and Appeals (DIA), Investigations Division, Audits Unit. Effective April 1, 2016, Contractor's obligations are only applicable to the Fee-For-Service population.
- d. For those funds received from providers related to MCO claims, research and process a

balance transfer or GAX to the appropriate MCO, and communicate and share data with the MCO related to necessary encounter claim adjustments.

6.6.4.3 Performance Standards

- a. Log and prepare all refund checks to be deposited in the state-owned Title XIX recovery bank account according to RFP Section 6.1.8 Banking Policies.
- b. Prepare and process credits or adjustments against refunds within ten (10) business days of receipt of the refund unless additional information is required to determine the action to be taken. This excludes the Medicare adjustment check, checks belonging to the Program Integrity unit, which are exempt from the timing requirement, and checks received in the IME Wells Fargo lock box that were not part of the Contractor's billing.
- c. If additional information is required in order to determine the action to be taken on the credit or adjustment related to a provider refund, request the additional information within five (5) business days of determination of the need for additional information.
- d. For refunds requiring additional information from the provider, enter claim credits or adjustments within five (5) business days of receipt of additional information from the provider.

6.6.5 Provider Withholds

This function consists of data entering the provider withhold liens in the MMIS, and monitoring the recoveries. The Revenue Collections contractor obtains withhold data from the Department of Administrative Services (DAS) Offset Program file, Department of Human Services (DHS) Child Support Recovery Unit, Internal Revenue Service and other sources as necessary.

6.6.5.1 State Responsibilities

- a. Monitor the contractor's performance of the provider withhold process.

6.6.5.2 Contractor Responsibilities

Effective April 1, 2016, Contractor's obligations under this section are only applicable to the Fee-For-Service population.

- a. Submit provider withhold data to the Core MMIS contractor.
- b. Meet the following objectives:
 1. Identify withholds against providers to be recovered from Medicaid payments.
 2. Recover withholds from claims submitted for payment and forward the recovered funds to the requesting entity.
- c. Maintain the following interfaces:
 1. DAS to obtain withhold data
 2. DHS Child Support Recovery Unit to obtain withhold data
 3. Internal Revenue Service to obtain withhold data
- d. Process all requests for withhold within one business day of receipt.
- e. Validate the processing of withhold within one business day after each adjudication cycle.
- f. Identify the provider number of the entity for which a withhold is required.
- g. Enter a withhold and assignment information to be used in directing or splitting payments

to the provider and the entity who has requested the withhold.

- h. Monitor the recovery of the withhold amounts and verify processing of withhold against the claims file.
- i. Ensure that the money amounts of each withhold do not exceed the state or federal regulations governing monetary garnishments.
- j. Implement a coordinated monitoring process with the MCOs to ensure that funds are not over-collected.

6.6.5.3 Performance Standards

- a. Process all requests for withhold within one (1) business day of receipt of request.
- b. Validate the processing of withhold within one business day after each adjudication cycle.

6.6.6 MEPD and IHAWP Premium Payments

The Medicaid for Employed People with Disabilities (MEPD) program is available to people who are disabled and have earnings from employment. The Iowa Health and Wellness Plan (IHAWP) provides comprehensive health care coverage to adults age 19-64 with an income up to 133 percent of the Federal Poverty Level. Some MEPD and IHAWP members are required to pay monthly premiums depending on their income level as a percent of poverty. This contractor is responsible for processing the MEPD and IHAWP premium payments.

6.6.6.1 State Responsibilities

- a. Initiate and interpret all policy and make administrative decisions regarding the MEPD and IHAWP programs.
- b. Notify the contractor regarding changes to the MEPD premium payment processing procedures.

6.6.6.2 Contractor Responsibilities

- a. Post all unprocessed batch payments received from MEPD or IHAWP lockbox to the system(s) designed to record MEPD or IHAWP premium information. The Department has established an automated bar coding system that electronically captures the required information. Most premium payment transactions are received from the bank electronically. For those that are not, the posting function will be a manual process.
- b. Request assistance from MEPD or IHAWP program manager for any MEPD payment for which the MEPD or IHAWP account cannot be determined.
- c. Notify MEPD or IHAWP program manager of items that are returned by a financial institution because of non-payment.
- d. Send any client correspondence sent to MEPD or IHAWP lockbox to the MEPD or IHAWP program manager for processing.
- e. Assist department with researching and viewing online lockbox transmittal information as needed.

6.6.6.3 Performance Standards

- a. For premium payment checks that are received, post the checks to the system designed to record MEPD or IHAWP premium information within one (1) business day of receipt from the bank.

6.6.7 Credit Balance Recovery

The Revenue Collections contractor will be required to pursue recoveries from Medicaid providers who have a credit balance and have no billing activity for at least 60 days.

6.6.7.1 State Responsibilities

- a. Establish and direct credit balance recovery policies.
- b. Establish the credit balance write-off threshold.
- c. Approve all requests for credit balance write-offs.

6.6.7.2 Contractor Responsibilities

Effective April 1, 2016, Contractor's obligations under this section are only applicable to the Fee-For-Service population.

- a. Follow-up on credit balances due to the Department from providers that have not been recouped through the claims processing system if there has been no activity for sixty (60) days.
- b. Refer to the Iowa attorney general's office any providers with credit balances who have filed for Chapter 7 or Chapter 11 bankruptcies.
- c. Refer to the Estate Recovery Services contractor any deceased providers with credit balances.
- d. If a provider is in a credit balance and their federal tax identification number matches that of an actively enrolled provider, prepare and submit the adjustment forms to transfer the credit balance amount to the actively enrolled provider.
- e. If the amount of the credit balance is below a threshold, as determined by the Department, prepare and submit the adjustment forms to write off the credit balance as bad debt.
- f. Within ten (10) business days of the provider being reported as being in a credit balance and having no activity for sixty (60) days, notify the provider by letter of the amount due and request that the provider send a refund check for the amount due.
- g. Prepare and process credits or adjustments against recoveries received within thirty (30) days of receipt of the recoveries.
- h. If the provider does not respond to the initial letter within thirty (30) days, send a second letter within 10 business days.
- i. If the provider does not respond to the second letter within thirty (30) days, telephone the provider within ten (10) business days to request the refund and log the date of the call and the response.
- j. If there is still no response after the telephone contact, refer the account to the Department within ten (10) business days with recommendations for other action to be taken by the Department.
- k. Record payments received in the IME accounts receivable system for generally accepted accounting principle (GAAP) reporting and bank account reconciliation purposes.
- l. Represent the Department at appeal hearings if the provider appeals the credit balance amount.
- m. Implement a coordinated monitoring process with the MCOs to ensure that all outstanding monies owed to the IME are recovered. This includes sharing historical

credit balances with the MCOs.

6.6.7.3 Performance Standards

- a. Prepare and process credits or adjustments against recoveries received within (30) days of receipt of the recoveries.
- b. Send initial provider notification letter within ten (10) business days of the provider being reported as being in a credit balance and having no activity for sixty (60) days.
- c. If the provider does not respond to the initial letter within thirty (30) days, send a second letter within ten (10) business days.
- d. If the provider does not respond to the second letter within thirty (30) days, telephone the provider within ten (10) business days to request the refund and log the date of the call and the response.
- e. If there is still no response after the telephone contact, refer the account to the Department within ten (10) business days with recommendations for other action to be taken by the Department.

6.6.8 Iowa-Based Yield Management Activities

Yield management describes the process by which Medicaid funds are recovered or cost-avoided through the review of claims that have been denied by a third-party insurer to ascertain whether the carrier's denial was appropriate and challenging the denial when it appears the insurer should have paid the claim.

6.6.8.1 State Responsibilities

- a. Monitor the Contractor's performance of the Iowa-based yield management activities.

6.6.8.2 Contractor Responsibilities

Effective April 1, 2016, Contractor's obligations under this section are only applicable to the Fee-For-Service population.

- a. Develop a process by which a denied or under processed claim with third-party insurance is reviewed for accuracy.
- b. Request additional information and challenge the denial or lack of payment when it appears the claim should have been paid by the third-party insurance carrier.
- c. Obtain all necessary Explanations of Benefits (EOBs) from the appropriate source. Forward the any EOBs to the Contractor's corporate office for data entry.

6.6.8.3 Performance Standards

- a. Provide monthly reports of yield management collections to the Department by the tenth (10th) of each month for the previous month's activities. If the tenth (10th) falls on a weekend or holiday, the report shall be provided no later than the next business day. The information in the monthly report shall include the total amount of Medicaid funds recovered.
- b. Provide a quarterly report with summary information for the most recent quarter to the Department by the tenth (10th) of each month for the previous quarter's activities. If the tenth (10) falls on a weekend or holiday, the report shall be provided no later than the next business day. The information in the quarterly report shall include the amount of Medicaid funds recovered in the previous quarter as well as the total year-to-date.

- c. Provide an annual report with summary information for the previous state fiscal year to the Department no later than August 15th of each year. The report shall be a compilation of the information from the quarterly reports.
- d. Update the comprehensive Iowa Operations Manual to reflect this activity within ninety (90) days of the effective date of this amendment to the Contract.

6.6.9 Medicaid Modernization Support

Contractor shall provide support of the Medicaid modernization effort underway at the Agency. This effort is expected to "go live" April 1, 2016. If the "go live" date is delayed in whole or in part, the parties agree to work in good faith to identify and address impacts to scope, timing and fees, and execute an amendment to the Contract equitably addressing the impacts.

Contractor shall perform the following transition services:

- Lien Recovery – Perform outreach to attorneys affected by the MCO transition to ensure they are aware of relevant changes.
- TPL Recovery – For disallowances, provide outreach to and coordinate with providers to ensure payments are sent to the correct locations.
- Provider Overpayments – Communicate with DIA about the MCO transition to ensure they are aware of relevant changes.
- Upon Agency request, create reports outlining historical data to use as a benchmark for the MCOs.

Staffing: Staffing will be modified during the transition period of April 1, 2016 through September 30, 2016. After the transition is completed, staffing will be reduced further as noted in the staffing plan below:

Timeframe	% FFS of Total Medicaid Population Previous Quarter	Local Staff*
Transition Period: 4/1/2016-9/30/2016	FFS Run-off	15.5 FTEs
Ongoing Operations: 10/1/2016-6/30/2017	5% or less	5.5 FTEs

*Reduction in local staff shall be offset by an increase in staff assigned at HMS's corporate facility, where most functions will be performed.

Performance Measures

- Contractor shall submit requested reports within 10 business days of Agency request. If programming is needed, Contractor shall notify the Agency and provide the timeline for delivery.